TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ADVANCED INFUSION SOLUTIONS

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-13-3016-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JULY 15, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our testing is done by a third party lab in Houston…When the results are in that we have the right drugs at the right potency, in a solution that is sterile and pyrogen free, the dispensing process can start. This process involves getting the medications to the patient in a manner that maintains the integrity, sterility and solubility of the compounded solution. Items included here are temperature controlled shipping, tamper proof packaging, electronic tracking, electronic proof of delivery, etc."

Amount in Dispute: $1,815.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided medication for a claimant's intrathecal infusion pain pump. The requestor billed place of service code 12, which, in this case, would be the claimant home. However, the submitted documentation does not substantiate where the pump was refilled, i.e. doctor's office, claimant's home, etc. Because of this inconsistency Texas Mutual declined to issue payment."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 10, 2012 March 8, 2013	HCPCS Code J7799 KD Pain Pump Refill	$695.00/ea	$285.00
December 10, 2012	CPT Code A9900 Miscellaneous DME supply, accessory, and/or service component of another HCPCS code	$300.00	$00.00
December 10, 2012	CPT Code A9901 DME delivery, set up, and/or dispensing service component of another HCPCS code	$125.00	$0.00
TOTAL		$1,815.00	$285.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code).
   - CAC-18-Duplicate claim/service.
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 878-Appeal (request for reconsideration) previously processed, refer to rule 133.250(H).
   - 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
   - CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - 714-Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly. Corrections must be submitted w/I 95 days from DOS.

Issues

1. Does medical fee dispute resolution have jurisdiction to review this dispute?
2. Is the requestor entitled to reimbursement for code J7799-KD?
3. Is the requestor entitled to reimbursement for code A9900?
4. Is the allowance of CPT code A9901 included in the allowance of another service rendered on the disputed date? Is the requestor entitled to reimbursement for code A9901?

Findings

1. The requestor provided professional services in the state of Mississippi on December 10, 2012 and March 8, 2013 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code§133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules..
2. The respondent denied reimbursement for code J7799-KD rendered on December 10, 2012 and March 8, 2013 based upon reason codes "16" and "225."

   HCPCS code J7799 is defined as "NOC drugs, other than inhalation drugs, administered through DME."

28 Texas Administrative Code §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

Trailblazers Health Enterprises published an article titled "Part B Drugs Used in an Implantable Infusion Pump" in October 2011. This article provided coding guidelines that indicate that "…compounded drugs used in an implantable infusion pump must be billed using Not Otherwise Classified (NOC) code J7799KD, whether a single drug or a combination of drugs is administered." This article goes on to state that "Compounded Baclofen (J7799KD) must be billed on a separate detail line of the claim from other J7799KD pain management drugs due to different limited coverage indications." A review of the submitted medical bill supports the requestor's position that HCPCS code J7799KD was billed in accordance with Medicare policy.

The respondent wrote "The requestor billed place of service code 12, which, in this case, would be the claimant home. However, the submitted documentation does not substantiate where the pump was refilled, i.e. doctor's office, claimant's home, etc. Because of this inconsistency Texas Mutual declined to issue payment."

The requestor wrote, "Our testing is done by a third party lab in Houston…When the results are in that we have the right drugs at the right potency, in a solution that is sterile and pyrogen free, the dispensing process can start. This process involves getting the medications to the patient in a manner that maintains the integrity, sterility and solubility of the compounded solution. Items included here are temperature controlled shipping, tamper proof packaging, electronic tracking, electronic proof of delivery, etc."

The requestor submitted invoices and pharmacy work orders to support that pain pump refills were delivered to claimant. As a result, reimbursement per Division rules and fee guidelines is recommended.

28 Texas Administrative Code §134.203(d)(1)(2) and (3) states, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

The Division finds that HCPCS code J7799KD does not have a fee listed in DMEPOS fee schedule nor a Texas Medicaid fee schedule.

28 Texas Administrative Code §134.203(f) states, "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

28 Texas Administrative Code §134.1(f) requires in pertinent part, that reimbursement shall: "(1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

The Division reviewed the submitted cost invoice and Advanced Infusion Solutions receipt and finds the following:

Medication	Concentration	Cost Per Unit per Invoice	Total Due
Preservative Free Morphine Sulfate	10mg/ml	$1140.00/ 80mgs	$14.25 X 10 mg = $142.50
Preservative Free Hydromorphone	Not listed	$557.50/gm	$0.00
Preservative Free Fentanyl Citrate	Not listed	$5.00/mg	$0.00
Preservative Free Sufentanyl	Not listed	$134.50/mg	$0.00
Preservative Free Clonidine HCL	Not listed	$118.50//mg	$0.00
Preservative Free Bupivacaine	Not listed	$52.66//gm	$0.00
Preservative Free Baclofen	Not listed	$33.60/mg	$0.00
Preservative Free Prialt	Not listed	Not listed	$0.00
TOTAL DUE		$1,044.26	$142.50 per date X 2 dates of service = $285.00

3. The requestor also billed CPT codes A9900 and A9901 that per Medicare guidelines are status "X" codes. Status X codes are defined as "Statutory Exclusion - These codes represent an item or service that is not in the statutory definition of 'physician services' for fee schedule payment purposes. No RVUS or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)" Because payment for these codes may not be made under the physician fee schedule; therefore, the Division refers to payment guidelines outlined in 28 Texas Administrative Code §134.1(f).

   28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." A review of the submitted documentation does not describe the item or service coded A9900 and A9901, nor the amount sought meets criteria outlined in 28 Texas Administrative Code §134.1(f). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $285.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $285.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		11/19/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.